

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050208

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No.

FILED JAN 3 1964

Primary Registration District No.

Registrar's No.

|  |                                      |   |   |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>                |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kirkwood</b>   |                                      | Length of stay in 1b<br><b>7 yrs</b>  | c. CITY OR TOWN <b>Kirkwood</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>10341 Manchester</b>   |                                      | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>10341 Manchester</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>MARY</b>  |                                      | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>27</b> Year <b>1963</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Caucasian</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-12-70</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (last birthday)<br><b>93</b><br>IF UNDER 1 YEAR<br>Months Days Hours Min.  |
| 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Missouri</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.</b>  |   |
| 13a. FATHER'S NAME<br><b>Michael DeLargy</b>   |                                      | 13b. MOTHER'S MAIDEN NAME<br><b>Bridget O'Bannon</b>  |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Edwrd J. Flesh (Dec)</b>   |                                      | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                    |   |
| 16. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT<br><b>Edward Flesh, 8330 Stanford</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO (b) <b>Cerebral arteriosclerosis</b><br>DUE TO (c) <b>Arterio-sclerotic Heart Disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Arterio-sclerotic Heart Disease</b> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b><br><b>10 yrs.</b>  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |                                      | 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 20f. CITY, TOWN, OR LOCATION   |                                      | COUNTY STATE  |   |
| 21. I attended the deceased from <b>1958</b> to <b>12-27-63</b> and last saw her alive on <b>11-8-63</b><br>Death occurred at <b>2:15</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.  |                                      | 22a. SIGNATURE (Degree or title)<br><b>James C Redington M.D.</b>   |   |
| 22b. ADDRESS<br><b>Clayton MO</b>  |                                      | 22c. DATE SIGNED<br><b>12-27-63</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                      | 23b. DATE<br><b>12-28-63</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>  |                                      | 23d. LOCATION (City, town, or county), (State)<br><b>St. Louis, Missouri</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Arthur J Donnelly, 3840 Lindell Blvd.</b>   |                                      | 25. DATE RECD. BY LOCAL REG.<br><b>12-27-63</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>John Murphy M.D.</b>   |                                      |   |   |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mr. James Redington  
950 Francis Pl.  
1A.00 - 545

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W. S. Salen

Licensed Embalmer No. 4699

P. O. Address 3840 Leland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.